

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/14/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>155365</b>		(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01</b> B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R</b> <b>08/10/2012</b>	
NAME OF PROVIDER OR SUPPLIER  <b>WABASH SKILLED CARE CENTER</b>				STREET ADDRESS, CITY, STATE, ZIP CODE <b>710 N EAST ST</b> <b>WABASH, IN 46992</b>			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
{K 000}	<p>INITIAL COMMENTS</p> <p>A Post Survey Revisit (PSR) to the PSR and Quality Assurance Walk-thru Survey conducted on 07/06/12 to the Life Safety Code Recertification Survey conducted on 05/09/12 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a)</p> <p>Survey Date: 07/06/12</p> <p>Facility Number: 000256 Provider Number: 155365 AIM Number: N/A</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</p> <p>At this PSR survey, Wabash Skilled Care Center was found in compliance with Requirements for Participation in Medicare, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This facility located on the third floor of a four story building with a basement determined to be of Type I (443) construction was fully sprinklered. This survey includes the entire third floor due to the lack of two hour separation between the Skilled Care Center and the remaining third floor occupancy. The facility has a fire alarm system with smoke detection in the corridors and areas open to the corridors. Battery operated smoke detectors were installed in the resident rooms. The facility has a capacity of 25 and had a census of 9 at the time of this survey.</p>			{K 000}			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{K 000}	<p>Continued From page 1</p> <p>The facility was found in compliance with state law in regard to smoke detector coverage and sprinkler coverage.</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 08/13/12.</p>			{K 000}			